TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dr. Peter E. Grays

Respondent Name
Great American Alliance Insurance

MFDR Tracking Number
M4-15-3679-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Your company has released payment but has denied payment for the procedure codes set forth below. I am now requesting a complete reconsideration of this claim with the review of the below rationale for all unpaid procedure codes, and request additional payment for my services rendered to the above claimant."

Amount in Dispute: $3,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier issue payment in the amount of $902.48. Carrier maintains that it has correctly calculated the reimbursement under the applicable fee guidelines and reimbursement policies."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2015	55520 -59, 64774 -59, 15271 -59, 15777 -59	$3,250.00	$920.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 397 – Allowance is based on utilization review pre-authorization

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration
- 59 – Processed based on multiple or concurrent procedure rules
- 329 – Allowance for this service represents 50% because of multiple or bilateral rules
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 217 – The value of this procedure is included in the value of another procedure performed on this date

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.203(b) states,

> For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
>
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Review of the submitted information finds that only one CCI edit is found for the services in dispute. Therefore the insurance carrier's denial reason is not supported for all the disputed services. The eligible disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The eligible services in dispute will be calculated as follows:

- Procedure code 55520, service date January 23, 2015. The Medicare fee is $443.10. A multiple procedure reduction of 50% of the allowed amount applies to this claim therefore the adjusted allowable is 443.10 x 50%= $221.55. The calculation formula (DWC Conversion Factor/Medicare Conversion Factor) x Medicare allowable or (70.54/35.7547) x $221.55 = $437.09. This amount is recommended.
- Procedure code 64774, service date January 23, 2015. The Medicare fee is $406.70. A multiple procedure reduction of 50% of the allowed amount applies to this claim therefore the adjusted allowable is $406.70 x 50% = $203.35. The calculation formula (DWC Conversion Factor/Medicare Conversion Factor) x Medicare allowable or (70.54/35.7547) x $203.35 for a MAR of $401.19. This amount is recommended.
- Procedure code 15271, service date January 23, 2015. The Medicare fee is $83.78. A multiple procedure reduction of 50% of the allowed amount applies to this claim therefore the adjusted allowable is $83.78

x 50% = $41.89. The calculation formula (DWC Conversion Factor/Medicare Conversion Factor) x Medicare allowable or (70.54/35.7547) x 41.89 for a MAR of $82.64. This amount is recommended.

- Per Medicare policy, procedure code 15777, service date January 23, 2015, may not be reported with the procedure code 15271 on this same claim. Review of the submitted claim finds the requestor did utilize the -59 modifier. However, the definition of 59 is, "Distinct Procedural Service - Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." The submitted documentation was insufficient to support the definition of distinct procedure service was met. No additional payment can be recommended.

3. The total allowable reimbursement for the services in dispute is $920.92. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $920.92. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $920.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $920.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.